AUTHORIZED PROVIDER APPLICATION AND ENROLLMENT

DELAWARE MEDICAL ASSISTANCE ENROLLMENT AND DEVELOPMENTAL DISABILITIES PROVIDER AUTHORIZATION*		
Name of Person/Organization:		
DE Business License Number:	Social Security Number/EIN/TIN:	Phone:
Current Street Address:		
City:	State:	ZIP Code:
Email Address:	Fax No.:	Contact Name:
Website Address (if applicable)		

BUSINESS TYPE*		
Sole/Individual Proprietor: Yes or No (circle one)		
Business Corporation – For Profit: Yes or No (circle one)		How long?
Business Corporation – Non-Profit:	Yes or No (circle one)	How long?
Limited Liability Partnership (LLC):	Yes or No (circle one):	How Long?
Other (Identify):	Yes of No (circle one):	How Long?
Copy of Tax ID number Provided:	Yes of No (circle one):	
Copy of Social Security Card Provided: **(Sole Proprietor Only)**	Yes of No (circle one):	

TYPES OF SERVICE(S) REQUESTING TO PROVIDE (CIRCLE ALL THAT APPLY)

1. Clinical Consultative Services:
   - Behavioral Services: Yes or No (circle one)
   - Registered Nurse Services: Yes or No (circle one)
2. Day Habilitation – Regular: Yes or No (circle one)
3. Pre-vocational Services: Yes or No (circle one)
4. Supported Employment Services: Yes or No (circle one)
5. Residential Habilitation:
   - Neighborhood Group Home: Yes or No (circle one)
   - Supervised /staffed Apartment(s): Yes or No (circle one)
   - Shared Living: Yes or No (circle one)

ALTERNATE CONTACT INFORMATION (IF APPLICABLE)		
Name:		
Address:		Phone:
City:	State:	ZIP Code:
Email Address:		

PROOF OF INSURANCE GENERAL LIABILITY*		
Name of Insurer:		
Type of Insurance:	Amount:	Effective Date(s):

PROOF OF PROFESSIONAL LICENSE (IF APPLICABLE)		
Name of Issuer:		
Name of Insured:		
Type of Insurance:	License Number:	
City:	State:	ZIP Code:
Position:	Hourly Salary *(Please circle)*	Annual income:

AUTHORIZED PROVIDER APPLICATION AND ENROLLMENT

PROOF OF AUTOMOBILE INSURANCE (SHARED LIVING PROVIDERS ONLY)

Name of Insurer:	Address:	Phone:
City:	State:	ZIP Code:
Position Title:	Email Address:	Fax No.:

OTHER REQUIREMENTS

Name on Drivers License:	State:
Driver's License No.:	Copy of Driving Record provided: **Shared Living Only** Yes or No (circle one)

SIGNATURES

I authorize the verification of the information provided on this form. I have retained a copy of this application for my records.

Signature of applicant:	Date:
Title: *(only if applicable):*	

***indicates that information is required**

Return this completed application and enrollment packet to:
DDDS Authorized Provider Committee
Woodbrook Professional Center
1056 South Governor's Avenue
Dover, Delaware 19904

Delaware Health and Social Services
Division of Developmental Disabilities Services
Office of the Director

INTERIM

APPLICATION
FOR
ENROLLMENT/ AUTHORIZATION
OF
WAIVER SERVICES PROVIDERS FOR DDDS

- Clinical consultative services
  - Consultative Nursing
  - Consultative Behavioral
- Day Habilitation
- Pre-vocational
- Supported Employment
- Residential Habilitation
  - Neighborhood Group Home
  - Staffed Apartment
  - Supervised Apartment
  - Shared Living

Division of Developmental Disabilities Services
Jane Gallivan, Director

Rev application/enrollment 3.12.12

INTRODUCTION

Pursuant to Section 6981(e), Title 29 of the Delaware Code, the Division of Developmental Disabilities Services (DDDDS) has established a process for enrollment/ authorization of service providers that elect to be considered for selection to provide day services (day habilitation, pre-vocational, supported employment); residential services (neighborhood home, supervised apartment, staffed apartment, shared living); consultative nursing; and/or consultative behavioral for people who are eligible to receive said services from the DDDS**. ALL SERVICE PROVIDERS MUST BE AUTHORIZED BY THE DDDS TO CONTRACT WITH THE DDDS.**

PROCESS

How to become an authorized provider: The interested agency must fill out an Interim Application to become an Authorized Provider Application. The application must be submitted with all required supporting documents as noted below in # 3.

AUTHORIZATION

The "Authorized Provider" classification that is issued by the DDDS is the prerequisite authorization that must be acquired by any agency or business that intends to be considered for selection to provide Day (Day Habilitation, Pre-Vocational, Supported Employment); Residential Habilitation (Neighborhood Home, Staffed Apartment, Supervised Apartment, Shared Living); Consultative Nursing; and/or Consultative Behavioral services for people who are eligible to receive services from the DDDS. Once authorized, the agency information will be placed on the DDDS Directory within 5 business days

The DDDS will authorize/not authorize providers on the basis of information submitted via the *Application for Annual Authorization of Day and Residential Service Provider.* Authorized providers will be assigned a classification (i.e., day habilitation, pre-vocational, residential, consultative nursing, etc), and notified of their status, in writing, by the DDDS within 10 business days of a determination. An applicant may request a review of the outcome of their application for authorized provider status by sending a written request to the Director within five business days of receipt of the Division's notification.

The DDDS will maintain a *Directory of Authorized Service Providers* that lists agencies and businesses that are qualified to be considered for selection to provide day, residential, consultative, and/or behavioral services for people who receive services from the DDDS. The *Directory* will be posted on the DDDS website, and available for review at the Office of the Director. With the exception of basic contact information, all other information submitted by providers via the application process will remain confidential to the fullest extent of the law.

GENERAL INFORMATION

The *Application for Authorization of Waiver Service Provider* may be obtained by calling the Office of the Director of the Division of Developmental Disabilities Services at (302) 744-9600, or by visiting the DDDS website at www.state.de.us/dhss/ddds/index.html

(1) Applicants are cautioned to answer all questions, and submit any ancillary documents with the application as requested. **An incomplete application may result in a delay or denial of authorization.**

(2) Completed applications (pages 5 thru 8) should be mailed to:

The Division of Developmental Disabilities Services
Woodbrook Professional Center
1056 South Governors Avenue, Suite 101
Dover, DE 19904

ATTN: APS COMMITTEE

(3) Faxed applications will not be accepted.

(4) An Authorized Provider shall report to the DDDS any material changes that could adversely affect the provider's authorized status within ten days of the material change. Notification must be submitted to the DDDS in writing and signed by the provider/provider's legal designee.

IMPORTANT NOTICE FOR NEW PROVIDERS

The DDDS understands the organizational and experiential challenges faced by service providers that are "just getting off the ground." As a result, new providers may not have all information requested in the application (e.g. survey results, vacancy information, staff turnover, etc). However, every applicant must complete the following application as thoroughly as possible, and attach copies of your (1) business plan*, (2) Delaware business license/proof on non-profit status and (3) notarized copy of certificate of insurance.

* Please see the *Authorized Provider System Business Plan Outline Minimum Required Elements* document at this DDDS web site.

IMPORTANT INSURANCE INFORMATION

All Authorized Providers that contract with the DDDS shall, at their own expense, carry insurance with minimum coverage limits as follows:

a) Comprehensive General Liability	$1,000,000
and	
b) Medical/Professional Liability	$1,000,000/$3,000,000
or	
c) Misc. Errors and Omissions	$1,000,000/$3,000,000
or	
d) Product Liability	$1,000,000/$3,000,000

All Authorized Providers must carry (a) and at least one of (b), (c), or (d), depending on the type(s) of service(s) being delivered.

If the service/contract requires the transportation of DDDS clients or staff, the Authorized Provider shall, in addition to the above coverage, secure at their own expense the following coverage:

e) Automotive Liability (Bodily Injury)	$100,000/$300,000
f) Automotive Property Damage (To Others)	$25,000

CHECK ALL THAT APPLY

CLINICAL CONSULTATIVE SERVICES
- ☐ Nursing Consultative Services
- ☐ Behavioral Consultative Services

DAY SERVICES
- ☐ Day Habilitation
- ☐ Prevocational
- ☐ Supported Employment

RESIDENTIAL SERVICES
- ☐ Neighborhood Group Home
- ☐ Staffed Apartment
- ☐ Supervised Apartment
- ☐ Shared Living

Delaware Health and Social Services
Division of Developmental Disabilities Services
Office of the Director

- ☐ Initial
- ☐ Renewal

Application for Waiver Service Provider

Submitted by (contact person):

Provider Name and Address:

Principal Office Location:

Phone Number:

FAX Number:

Email Address:

Website Address:

Delaware Business License Number:

Federal E.I. Number:

Please indicate if either of the following authorizations (through the Office of Minority and Woman Business Enterprises) applies to your business:

Minority-Owned Business Enterprise

☐ Yes – Authorization No. _____ ☐ No

Women-Owned Business

☐ Yes – Authorization No. _____ ☐ No

If you answered "No" to either of the above, and your business is eligible to be authorized as either through the Office of Minority and Women Business Enterprises, you are encouraged to apply for said authorization. For more information, please visit www.state.de.us/omwsbe/.

Authorization Evaluation Criteria

Complete all sections. If something is not available, enter "N/A" in the applicable section.

Mission Statement and Philosophy of Service:

What are the mission, history, and philosophy that underlie your delivery of services?

Programs, Services, and Performance:

1. Describe the types of programs and services offered, and populations served.
2. Specifically describe your past experience in providing services to persons with developmental disabilities. Additionally, describe your service delivery for this population.
3. Summarize the most recent Consumer/Family Satisfaction Survey.
4. Summarize the most recent Staff Satisfaction Survey.
5. What are your rates regarding (a) staff vacancies and (b) staff training compliance?
6. Submit as enclosures:
    A. Three letters of reference from organizations that can attest to the current quality of your delivery of services
    B. One sample of a consumer service plan
    C. One copy of your quality improvement/strategic plan

Health and Safety:

1. List all of your national or other accreditations.
2. List and explain any programs or services that you offer that are under any probationary or other problematic status.
3. List the current licensing authorizations you hold in the state in which you are incorporated.
4. List and explain any suspension or revocation of service licenses or authorizations.
5. List and explain any current or pending litigation.
6. Submit as enclosure:
    D. One copy of your Emergency Operation Plan (EOP)

Policies, Procedures, and Quality Assurance:

1. Describe your quality assurance system.
2. Submit as enclosures:
    E. One copy of Rights Policy
    F. One copy of Abuse/Neglect Policy
    G. One copy of Risk/Incident Management Policy
    H. One copy of Appeals Process
    I. One copy of Training Policy

Business Practices:

1. Describe your governing body.
2. Submit a copy of your Table of Organization.
3. Submit a copy of your Operational Plan.
4. Describe your internal auditing system, including audit schedules.
5. What is your current "Authorized Medicaid Provider" status?
6. Describe your ability to initiate and deliver HCBS waiver services on an ongoing basis.
7. Describe your pre-employment screening criteria and process.
8. Submit as enclosure:

    J. Notarized letter from a CPA firm attesting to the nature of your 1) historical and current financial management practices, 2) debt to income liquidity ratio, and 3) possession of a 60-day cash reserve.

    K. Notarized copy of certificate of insurance.

    L. Submit a copy of your Business Plan

NOTE: THE STATE RESERVES THE RIGHT TO CONTACT ANY APPLICANT TO DISCUSS OR REQUEST ADDITIONAL INFORMATION REGARDING ANY ASPECT OF THIS APPLICATION

ACQUISITION OF AUTHORIZED PROVIDER STATUS DOES NOT GUARENTEE THAT A AUTHORIZED PROVIDER WILL BE SELECTED TO PROVIDE SERVICES (I.E., ISSUED A CONTRACT)